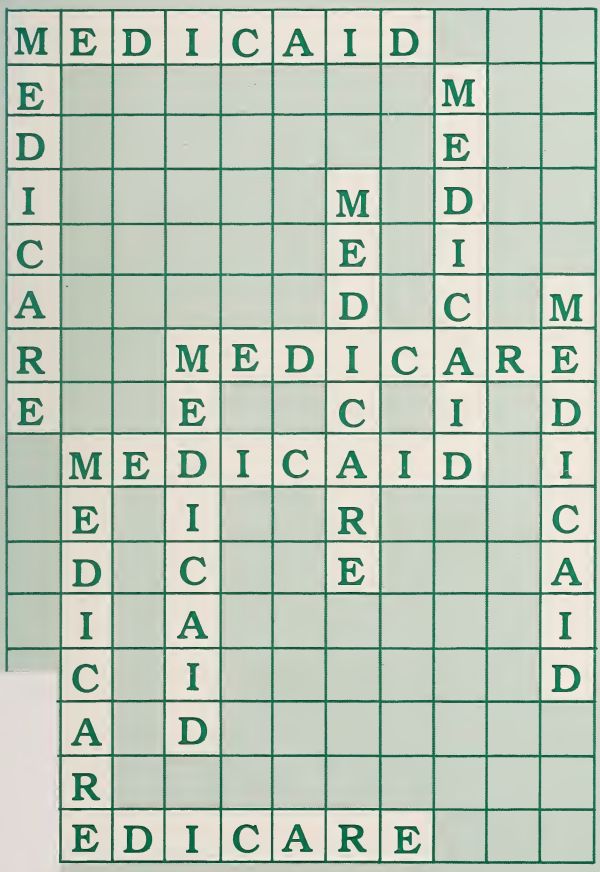
MEDICAID MEDICARE

"Unpuzzling" The Programs



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A PHYSICIANS GUIDE TO MEDICAID

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MEDICAID . . .
MEDICARE . . .
UNPUZZLING THE PROGRAMS

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The HEALTH CARE FINANCING ADMINISTRATION was established to combine the Department's health financing and quality assurance programs into a single agency. HCFA is responsible for the Medicare program, Federal participation in the Medicaid program, the Professional Standards Review Program and a variety of other health care quality assurance programs.

The mission of the Health Care Financing Administration is to promote the timely delivery of appropriate, quality health care to its beneficiaries—approximately 47 million of the nation's aged, disabled and poor. The Agency must also ensure that program beneficiaries are aware of the services for which they are eligible, that those services are accessible and of high quality and that Agency policies and action promote efficiency and quality within the total health care delivery system.

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Preface

Medicaid and Medicare have many similarities. They are both government-sponsored health programs; they sound alike; they even have exactly the same number of letters!

In our first booklet in this three part series **Medicare Is . . . But Is Not** you learned about the Medicare program. Now in our second feature **Medicaid . . . Medicare Unpuzzling the Programs** you are about to learn about the Medicaid program.

As a new physician you will need to know the **differences** between these two programs. You will need to know what each program **is,** what each program **covers,** and what each program **means** to you and your patient. If you get confused and the distinctions between the two programs start to blur in your mind, you may be in for a little frustration.

But there's no need to worry. To make things easier for you we are describing Medicaid by showing how it differs from and relates to Medicare. In this way we hope to give you a clear, precise idea of what the Medicaid program is all about.

Again we wish you the best of luck in your new profession and sincerely hope that this booklet will help you and your patient get the most out of the Medicaid program.

Virginia M. Smyth
Regional Administrator
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Foreword

In the foreword of **Medicare Is . . . But Is Not** we told you that Medicare was signed into law on July 30, 1965, by President Johnson in the Harry S. Truman Library in Independence, Missouri. What we neglected to tell you then is that on the same day, another government program was born—the Medicaid program.

Medicaid like Medicare was conceived as an idea in the 1930's. The Great Depression spawned concern about the cost of health care for the poor as well as the aged. About 25 million people (one-fourth of the population) were unemployed in 1935. Jobs were scarce. Food was scarce. And money to pay for hospital and doctor bills was even more scarce. Everyone, particularly the poor and the aged, felt a great and ,powerful financial insecurity.

President Franklin D. Roosevelt and the Congress therefore in an effort to protect the aged and the poor from calamities like the Great Depression, passed the Social Security Act of 1935. The Social Security Act created a system of social insurance for the aged **and** a system of public assistance for the poor.

The system of social insurance came to be known as Social Security. The system of public assistance had a variety of names depending upon the category of assistance a person was eligible to receive.

People had to earn the right to receive Social Security in that they had to work a certain length of time to qualify for regular monthly checks at retirement. To be eligible for public assistance or "welfare" checks people must be poor and fit into one of several categories of need: families with dependent children, aged, blind or disabled.

As time went on health care costs rose higher and higher. By 1965 the need for health programs for the elderly and the poor had become readily apparent. After many weeks of hearings Congress passed legislation as an amendment to the Social Security Act of 1935.

The legislation added two new titles to the Social Security Act—Title XVIII or Medicare a health insurance program for people over 65 and Title XIX or Medicaid a medical assistance program for the needy.

Medicaid and Medicare, therefore, really are twin government programs. In the next chapter you'll get to see if they are identical or fraternal twins.

Chapter 1

MEDICAID-MEDICARE WHICH IS WHICH?

Medicare and Medicaid are **fraternal** not identical twins. In some ways they are alike but in many other ways they are decidedly different.

One big difference is that Medicare is a health insurance program for people 65 and over and qualifying disabled people regardless of income. Medicaid is a medical assistance program for needy people only.

Medicare is financed through Social Security taxes and monthly premiums. Medicaid is financed jointly by the State and the Federal government. The Federal government pays from 50% (in prosperous States) to 78% (in poor States) of all Medicaid costs. States pay the remaining Medicaid expenses often with help from local governments.

Medicare covers the same services and supplies in every state in the Union. Medicaid is (would you believe) 53 separate programs! Each state has its own version of Medicaid and each state administers its Medicaid program independently within Federal guidelines.

Why does each state have so much autonomy in administering its Medicaid program? It's really very simple. Since each state pays a healthy portion of its own Medicaid costs, it has the right to specify what services can be covered for its people.

You will usually find that wealthy states with large populations will provide for a broader range of Medicaid services than smaller less populous states. For this reason the States of New York and California alone account for 32% of all Medicaid expenditures.

How is this money spent and for what services? Are you curious? Great.

In the next chapter we are going to talk about covered services.

Chapter 2

MEDICAID-WHAT IT PAYS FOR

Each state has a slightly different Medicaid program covering different services at different rates for different categories of people. A state may determine the scope of services covered. (It may for example limit the days of hospital care or the number of physician visits per illness that can be covered.) A state may determine the reimbursement rate for medical services. (For example, one state may pay a physician more for an office call than another state.) And, a state may decide who is eligible for Medicaid within its boundaries.

Can a state change its mind about its Medicaid program? Yes. It most certainly can. As long as the program remains within Federal guidelines, a state's legislature or Medicaid Agency, can add or subtract services from its Medicaid program.

Title XIX of the Social Security Act does require the state to pay for the following basic services:

Inpatient hospital care;

Outpatient hospital care and rural health clinic services;

Other laboratory and x-ray services

Skilled nursing facility services and home health services for people over 21 years of age;

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for people under 21 years of age;

Family planning services; and

Physician services

If they want to, States may also provide a number of other services for their Medicaid people. States may cover drugs, eyeglasses, private duty nursing, intermediate care facility (ICF) services, inpatient psychiatric care for the aged and persons under 21, physical therapy, dental care, etc.

States may also limit coverage on these optional services. For example, some states cover only certain kinds of prescription drugs and certain kinds of dental treatment.

Medicaid is not divided into parts like Medicare. There is no Part A or Part B to Medicaid. Part A and Part B Medicare you remember are paid out of separate trust funds—the Part A trust fund comes from our Social Security taxes and Part B comes from premiums paid by Medicare patients (1/3) and general tax revenues (2/3).

Each state's Medicaid plan is a single entity covering many of the same things that Medicare covers. Medicare as you recall pays for the inpatient hospital care, skilled nursing care and home health services (Part A) and physicians services and other specified services (Part B).

Medicare (Part A) pays inpatient hospital care and skilled nursing care according to 90 day benefit periods and also requires the Medicare patient to share part of the cost through the Part A deductible and coinsurance. Medicaid pays according to days of care because it is a program for needy people who cannot afford to pay deductibles and coinsurance.

The number of inpatient hospital days Medicaid can cover varies from state to state. Medicaid also can pay for medically necessary skilled nursing care and intermediate care.

Intermediate care means that a patient needs nursing care but not on an "around the clock" basis. We will talk some more about intermediate care in Chapter 7.

Like Medicare, Medicaid can also pay for services provided by a certified Home Health Agency. A Medicaid certified Home Health Agency must provide skilled nursing services, home health aide services, medical supplies equipment and appliances.

Medicaid does not require a patient to have been in a hospital for three days in a row or that home health care be related to treatment received in a hospital or skilled nursing facility. Medicaid can pay for home health visits only when you prescribe the visits as a part of a written home health plan. The State Medicaid agency determines the total number of visits covered in a calendar year. So, remember if your patient does not need treatment from a hospital or skilled nursing facility, home health agencies are available to help you and your patient.

Part B Medicare requires the patient to pay a deductible of $60 and also 20% coinsurance and the difference between the reasonable charge and your actual charge. Medicaid, on the other hand, pays a specific amount for each doctor's service in the state.

You also do not have to worry about accepting or not accepting assignment. All Medicaid claims are "assigned" claims. The law requires you to accept the Medicaid payment as the full charge for your services. You would, therefore, not bill the Medicaid patient. You would bill the state Medicaid agency or fiscal agent for any services you provided.

As you might suspect it is possible for an elderly or disabled person to be entitled to **both** Medicare **and** Medicaid. What happens then? Who pays for what?

Well, Medicare is always the first to pay for any services covered by both programs. After Medicare has paid its share on a hospital or doctor's service, Medicaid may pay a portion of the remaining costs. (For example, Medicaid may in some states pay the $60 Part B Medicare deductible and the 20% coinsurance.)

Do you find our description of Medicaid coverage rather sketchy? Well, unfortunately it has to be that way. Medicaid coverage differs greatly from state to state. The best thing for you to do when you begin to set up your medical practice is to contact the Medicaid agency or fiscal agent in your state for all the details about Medicaid coverage.

Chapter 3

WHO IS ELIGIBLE FOR MEDICAID?

The most controversial and complex aspect of the Medicaid program is eligibility. Deciding who is eligible and when is not a simple matter as it is with Medicare. To be entitled to Medicare you just need to have worked a particular length of time, and be 65, disabled or have chronic renal disease. To be eligible for Medicaid a person must meet certain income requirements and fit into one of several categories of eligibility.

A person can automatically become eligible for Medicaid by becoming eligible for a State cash assistance program. For example, anybody who is eligible for the Aid to Families with Dependent Children (AFDC) program is also eligible for Medicaid coverage. In addition in **most** states anybody who's eligible for the Supplemental Security Income (SSI) program is also eligible for Medicaid.

To get AFDC a child has to be deprived of the support and care of one or both parents. This sad situation occurs when one or both parents either leave their home and family or else become physically or emotionally incapacitated.

"Losing" a parent's support or care does not, however, automatically qualify a child for AFDC. The family must meet numerous financial requirements and these differ from state to state.

The SSI program was passed as an amendment to the Social Security Act (Title XVI) in 1972 and is a Federal program. SSI is, therefore, the same in every state and the Social Security Administration decides what people are eligible.

To get SSI a person must be aged, blind or disabled and meet certain income criteria.

An SSI person can work but there's a limit on how much he or she can earn per month. An SSI person can work and earn up to $85 per month without having the SSI check (the standard SSI payment is now $238.00 per month) affected. For every $1 earned over the $85 work limitation the person loses $2 in benefits. For example, let's say 66 year old Hazel Sanders applied for SSI at her local Social Security Office and is receiving SSI checks. She earns $541.00 per month. How much of her SSI check can she have?

Very good. The answer is **$10.** ($541.00 $85 = $456; $456:-2 = $228.00; $238 (the standard SSI payment) - $228 = $10.)

Are there any other limitations on Hazel's income? Yes, many more.

There is a limit on the amount of unearned income (pensions, annuities, etc.) Hazel can have. The first $20 in unearned income she gets is not counted but after that, every dollar of unearned income she receives, reduces her SSI check. So, for example if she quit her job and started getting a Social Security check of $258, can she still receive her SSI check?

No. (Your're right again.) $258 - $20 = $238; $238 - $238 = 0)

Does Hazel have to be completely destitute to receive her SSI check? No, not really. She can own a house, a car and have up to $1500 in the bank and still get her SSI check.

There are of course, many other restrictions on Hazel's income and resources but we need not discuss them here. The point is she's got to be aged, blind or disabled **and** meet numerous income and resource requirements to get SSI.

Becoming eligible for SSI or AFDC are **not** the only ways to qualify for Medicaid. There are about 29 other mandatory and optional coverage groups. Mandatory coverage groups are people that Federal law requires a state to cover in their Medicaid program. Optional groups are people that Federal law permits a state to cover in their Medicaid program but who do not have to be covered.[1] Here are some examples of mandatory coverage groups:

(1) Even though under the AFDC program a state does not have to pay money to children over 18, Federal law requires that Medicaid be extended to any children otherwise eligible for AFDC up to age 21.

(2) A state that offers Medicaid coverage to SSI people must offer Medicaid to people who lose their SSI benefits solely because of a cost of living increase in their Social Security Check.

[1]A listing of the groups covered by each State in the Southeast is in **Appendix B.**

Examples of optional coverage groups are:

(1) Under the AFDC program a state can if it wishes, provide assistance to unborn children. This assistance can be in the form of cash money and/or Medicaid coverage.

(2) A state may also provide Medicaid to aged, blind and disabled people who are in skilled nursing homes or intermediate care facilities.

(3) A state can provide Medicaid to people who are "medically needy." The term "medically needy" does not refer to people who are victims of catastrophic illness. The medically needy option is an extension of Medicaid coverage to people whose income and resources just barely exceed the limits set by the states.

A key provision of most states medically needy programs is called "spend down."

What is "spend down?" Let's look at an example.

Linda Lou Cates lives in Tennessee. She has a job which gives her a net income of $451 per month. Her net income ($451) is $100 more than she's allowed to earn and still get cash assistance and Medicaid from the state. The state assigns her a 3-month "spend down" period—June, July and August of 1980. Between June 1, 1980 and July 10, 1980, Miss Cates gets sick and incurs $100 in medical bills. From July 10 until the end of August Miss Cates is eligible for Medicaid!

Why? Because Miss Cates has "spent down" or spent away her excess income of $100.

Beginning September 1, 1980, Miss Cates would be assigned another 3-month period and once again she'd have to "spend down" her extra $100 in excess income.

How does Miss Cates prove that she actually did incur $100 in medical expenses? She gets an itemized statement from her doctor for the services she received and submits it to the state.

If you think one of your patients might be eligible for Medicaid in your state just ask him or her to call the local welfare department.

One final note. Despite the ifs, ands and but's of this ambiguous chapter, there is one thing you can be sure of. Federal guidelines require that **all** states permit a person 3 months of Medicaid coverage before the date the person filed for benefits provided that the person had incurred unpaid medical bills for those three months.

Therefore, if Emily Hall got sick and had medical expenses in January, February and March 1980, but she didn't file for Medicaid until April 1980, the state would have to start her coverage—when?

You are so right. In January, 1980.

Chapter 4

MEDICAID CLAIMS— GETTING THE MONEY THAT'S DUE YOU— FAST

The object of the Medicaid program is really two-fold—to help poor people and to see that you the physician are paid promptly and in the correct amount for your services. You and your patient are really what's important. Congress designed Medicaid to strengthen not to weaken the doctor/patient relationship Medicaid allows poor people to receive and physicians to provide quality medical care in a dignified way. The Medicaid patient does not have to worry about or be ashamed of his inability to pay for your services and you don't have to feel obligated to provide medical service gratis to poor people.

To receive a Medicaid payment you need to file a Medicaid claim for your patient. (Inpatient hospital claims, skilled nursing facility claims and intermediate care facility claims are filed by the facility for the patient.) And, since each state has a slightly different Medicaid program; each state will also have a slightly different Medicaid claim form.

Intimidated? Irritated? Don't be, there's no need. All Medicaid claim forms are much alike. All a person has to do is follow two cardinal rules: read the instructions carefully and fill in all the blocks on the form. Missing just one block on a form can delay the processing of your claim.

Again, as with Medicare a well-trained medical assistant staff is a must for getting your Medicaid claims paid promptly. For you see unlike Medicare the Medicaid law **requires** that you receive prompt payment.

Here's what Chapter 447.45 of the Medicaid law says:

(1) The Medicaid agency must require providers to submit all claims no later than 12 months from the date of service.

(2) The agency must pay 90 percent of all clean claims (we'll define clean in just a moment) from practitioners who are in individual or group practice or who practice in shared health facilities within 30 days of the date of receipt.

(3) The agency must pay 99 percent of all clean claims from practioners who are in individual or group practice in shared facilities within **30 days** of the date of receipt.

(4) The agency must pay all other claims within 12 months of the date of receipt.

What is a "clean" claim? Again, let's quote the law:

"Clean Claim" means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a state's claim system. It does not include a claim from a provider who is under investigation for fraud or abuse or a claim under review for medical necessity.

So you see as long as your medical assistant staff files "clean" claims you are in good shape. You are protected by the law. You are not subject to the sometimes seemingly capricious behavior of government agencies!

Medicare claims are processed by private insurance companies through contracts with the Federal government. Part A Medicare claims are paid by organizations called intermediaries. Part B Medicare claims are paid by organizations called carriers.

Medicaid claims (both hospital **and** medical) are processed either by a state agency or a fiscal agent (An insurance company or other group with a government contract).[2]

Your first contact with a Medicaid state agency or fiscal agent will of course be when you apply to participate in the program. How do you apply?

Again, as with Medicare it's very simple. You just call or write the state agency or fiscal agent and a week or so later you'll receive a provider number (usually your social security number) and a package of claims forms and a Medicaid manual outlining what medical procedures are covered by the program.

From time to time you'll be mailed "transmittals" (another standard government term) advising you of changes in your state's Medicaid program. It will be your responsibility to see that someone on your medical staff reads these transmittals carefully and files them for future reference.

[2]**Appendix A** is a listing of all Medicaid fiscal agents and State agencies in the Southeast.

Now that you know about the Medicaid claim form we should discuss another important item—the Medicaid card. You can't file a Medicaid claim without a Medicaid card!

Medicaid cards differ from Medicare cards in several ways. Medicare cards are usually good for a lifetime. Medicaid cards are issued once a month and are usually good for only that month.

Medicaid and Medicare cards are also different colors. Medicaid cards may be green, yellow, white or whatever suits the fancy of the state. Mediciare cards are **always** red, white and blue. Medicaid cards also have a claim number that does not resemble the Medicare number (A Medicare claim number is a person's Social Security number plus an alpha suffix like A, B, C, etc.)

If a person has private health insurance, you should file a claim with the private insuror first. Medicaid is the payor of last resort. Filing a claim with Medicaid first will probably delay **any** payments to you because Medicaid will in all likelihood send the claim back and ask you to bill the private insurors. Additionally,, most private insurance companies pay higher rates than Medicaid.

There will be times when patients lose their Medicare or Medicaid cards. Tell your medical staff if this happens not to be alarmed. All they have to do is advise the patient to contact the local Social Security office for a new Medicare card and their local Medicaid or Welfare Office for a new Medicaid card.

This has been a long but important chapter because it concerns money—money that you deserve for the services you provide Medicaid patients.

Whenever problems occur don't forget your state Medicaid agency or fiscal agent is only a phone call away. Each state agency or fiscal agent has a specially-trained professional relations staff that will be ready to help you in any way they can.

*See **Appendix A**

Chapter 5

EPSDT—WHAT IT MEANS? WHY IT MATTERS?

EPSDT stands for Early and Periodic Screening, Diagnosis and Treatment and is an important part of the Medicaid program. Why? Because EPSDT is specifically designed for people under 21 years of age.

EPSDT is intended to detect and treat diseases that may occur early in a child's life. As you well know, some health problems begin early and if left untreated can sentence a child to a lifetime of chronic illness and disability.

The EPSDT program works like this. Each state is required to identify eligible children under 21 (A child eligible for Medicaid is automatically eligible for EPSDT) and within 60 days inform the family what services are available and where they can be obtained.

Once the family is informed it is up to the mother or father to decide whether to enroll the child in the EPSDT program. If the family chooses to enroll the child, the state is required by the Medicaid law to have the child complete the EPSDT program within 120 days (75% of the time) or within 180 days (95% of the time).

Why all this business about percentages of time and days? The answer is very simple and direct—time. Time is as you know, a critical element in treating diseases in young children. For this reason the Medicaid law requires the state to see that the EPSDT program works as a quick efficient process.

The EPSDT program must evaluate a child's physical and mental health and his growth and development. Children will usually have the following areas examined: vision, dental problems (children over age 3 must in all states be directly referred to a dentist to have their teeth checked), hearing, growth and development, nutrition, immunization against diseases like measles, polio, whooping cough, diptheria, mumps and tetanus, heart disease, kidney disease, diseases of the ear, nose, mouth and throat, anemia and sickle cell anemia, parasites like pinworms, hookworms, lead poisoning and drug abuse.

EPSDT is not only for children with obvious health problems but also for children who seem well. If someone, be it a parent or employee of a state welfare department, suspects that a child does have an illness or defect, the child will be immediately referred to a physician or clinic for further examination and treatment.

Each state's EPSDT program must provide eyeglasses and hearing aids to eligible children who need them; it must provide transportation to the doctor's office if necessary; and, it must see that each child has a health history established for follow-up purposes.

Sure you say. EPSDT. I understand its purpose and basically why the program was instituted but what does it mean? Just exactly what do you mean by periodic screening, diagnosis, treatment, etc. Well ladies and gentlemen, you are about to find out. Here are definitions you might want to remember.

(1) PERIODIC

Each State's Medicaid plan must provide that children eligible for Medicaid be screened at regular intervals early in life. (e.g., at birth, at 6 months etc.) The State Medicaid agency informs the parents of a Medicaid child when an examination is due.

(2) SCREENING

Screening is the use of procedures to sort out apparently well persons from those who have a disease or abnormality and to identify those in need of more definitive study of their physical or mental problems. Screening may be performed by a physician or through a county health department. When a child is screened and an abnormality is found, the Health Department refers the child to a physician for diagnosis and treatment.

(3) DIAGNOSIS

Diagnosis is the determination of the nature or cause of suspected physical or mental abnormality through the combined use of health histories, physical, developmental and psychological examinations, laboratory tests and x-rays. Although, in some instances diagnosis may be made at the time of screening, it will usually be necessary for the patient to visit an appropriate practitioner or medical facility for definitive evaluation.

(4) TREATMENT

Treatment means physician's or dentist's services, hospital services, or any other Medicaid services to prevent, correct or ameliorate disease or abnormalities detected by screening and diagnostic procedures.

Chapter 6

WHO DOES WHAT IN THE MEDICAID PROGRAM— THE FEDERAL-STATE RELATIONSHIP

Throughout this booklet you've been hearing the words Federal and State very often. Why? Because the Federal Government and the States are partners in the Medicaid program. Medicaid is run by each individual **state** but according to **Federal** guidelines.

The Health Care Financing Administration establishes under the authority of the Secretary of the Department of Health and Human Services, regulations to administer the Medicaid Program.

The Health Care Financing Administration is headquartered in Baltimore and has ten regional offices located in major cities throughout the country. The Regional Offices oversee each state's administration of the Medicaid program. They analyze and review each state's Medicaid budget, projected expenses and the methods and procedures used to carry out the program.

The Federal Government pays at least 50% of the Medicaid cost in each state and the state pays the rest. A state's legislature or Medicaid Agency decides what optional services are covered, when they are covered and for whom they are covered (based on Federal requirements).

Federal law requires that a state have a single state agency run its Medicaid program. The Medicaid program may be administered through an independent agency or through the State Department of Human Resources, the State Health Department, etc.

Should you have a question or complaint about Medicaid coverage in your state, please contact your state Medicaid agency or fiscal agent. If you disagree with a particular Federal guideline, you should contact the Regional Office of the Health Care Financing Administration (HCFA).

Chapter 7

NURSING HOMES

"Nursing Homes" how those two little words get peoples' minds to working! Everyone has a definite opinion about nursing homes. Everyone has a definite conception of what nursing homes do. And everyone, it seems entitled to Medicare or Medicaid or in any way associated with these two programs, at times gets confused about what **kinds** of nursing homes are available.

Whenever you talk about nursing homes you must first mention levels of care. There are three primary levels of care in the marvelous health care system you are about to join. Here they are in descending order:

(1) SKILLED NURSING CARE—Skilled nursing care is most often provided in a skilled nursing facility (SNF). A skilled nursing facility provides 24-hour nursing services to patients who are still extremely ill but who do not need the type of services available in a hospital setting.

(2) INTERMEDIATE CARE—An intermediate care facility provides, on a regular basis, health related services to individuals who do not require hospital or skilled nursing care, but whose mental or physical condition requires services that are above the level of room and board and can only be made available through institutional facilities.

(3) CUSTODIAL CARE—Custodial care is assistance a person needs to help meet the normal daily needs of living (eating, dressing, walking, etc.). Care that is primarily custodial is not covered by **Medicaid** or **Medicare.** States set their own standards for this level of care when it is available.

It will be your responsibility as a physician to certify in writing whether a person needs skilled or intermediate nursing care. With your medical expertise, the medical evidence at hand and your knowledge of the Medicare/Medicaid programs such decisions should be a breeze!

Before we do any more congratulating, there are a few more things you should know about Medicare/Medicaid coverage. Medicare pays up to 100 days in a skilled nursing facility per benefit period. Medicaid has no limits on the number of days in a skilled nursing facility for which it can pay. Medicaid also does not require a prior hospital stay for services to be covered.

A nursing facility can be certified as a skilled nursing facility (SNF), an intermediate care facility (ICF) or both. If a patient has **Medicaid** he or she can have skilled nursing care and/or intermediate care paid for. If a patient has Medicare only, the first 100 days of skilled nursing care in a benefit period can be paid for.

What if Linda Lou Cates has Medicare/Medicaid. She's been in the hospital 5 days and meets all the requirements to have Medicare cover 100 days of her stay in Danville Skilled Nursing Center. Then as time goes on you realize that Linda will need a total of 105 days of skilled nursing care to really get herself back on her feet and smiling again.

Will Linda Lou have to pay the extra 5 days out of her own pocketbook? The answer is no. Since Linda has Medicaid she need not worry. As long as the care is medically necessary, Medicaid can cover whatever additional days she needs.

Both skilled nursing facilities and intermediate care facilities must meet Federal health and safety standards to participate in the Medicare/Medicaid programs. Each state must follow these standards when it inspects and certifies nursing homes to receive money from Medicaid and Medicare.

To find out whether an intermediate care facility or skilled nursing facility is certified for Medicaid and/or Medicare, just contact the facility or your Medicaid stage agency or fiscal agent.

Chapter 8

THE MEDICAID PATIENT—A PROFILE

What is a Medicaid patient really like? Is there a typical Medicaid patient? Well, as you observers of life in the 1980s know, (watch out, you may be in for some philosophy!) nothing and nobody is typical.

Medicaid people are just that—people. They are not patients; they are not recipients; they are not claims; they are real flesh and blood people with doubts and fears, hopes and dreams, goodness and badness just like the rest of us!

First of all Medicaid patients for one reason or another are **poor.** Some have been poor since birth; others were doing fine until they were beaten down by the passage of time or some insidious disabling disease.

Since Medicaid patients are poor, they become victims of a vicious circle. The fact that they are poor makes them more often sick and the fact that they are more often sick keeps them permanently poor.

It's not a pretty picture is it? It's stark; it's uncompromising; it's **real!**

Do you know what the saddest fact about the Medicaid program is? It's that most Medicaid people (approximately 49% in 1978) are children—poor, helpless children who because of an accident of fate would not have access to adequate medical care without Medicaid.

For this reason the **EPSDT** program discussed in Chapter Five is doubly important. These little lives can be salvaged. Through **EPSDT** diseases that affect children can be detected and treated early so that our little people can have the opportunity to lead normal productive lives.

Right?

The other 51% of the Medicaid population are elderly, disabled, blind or parents of dependent children. They too need help in the worst way.

These are the kind of people you will be meeting and treating as a new physician.

It is for these people that the Medicaid program has been created.

Chapter 9

STAYING WITHIN THE LAW

You will see fraud or abuse in the Medicaid program as well as the Medicare program. Medicaid is abused by recipients, physicians, suppliers and other providers of medical services.

Why are we so concerned about fraud and abuse of the Medicaid program? Well, first of all it **is** illegal and more importantly because it is such a **waste,** such an obscene **waste** of everyone's tax dollars.

An estimated 5% of Medicaid expenditures are wasted on fraudulent or unreasonable payments. Do you know how much money that comes to in one year? Millions and millions of dollars.

Despite what you may think, we in HCFA do not **like** to "lose" money. For this reason we have tightened up our management of the Medicaid program and created more strict indepth investigative procedures to cut losses in the future.

Each State has a special investigative unit to combat fraud and abuse in its Medicaid program. The Office of Program Integrity of the Health Care Financing Administration makes assessments of each state's fraud and abuse activities, makes recommendations for improvement and issues reports of its findings to the Secretary of the Department of Health and Human Services.

Examples of Medicaid fraud are billing for services not rendered or misrepresenting services that are rendered (e.g. billing for an office visit and complete history when only a routine office visit took place). Examples of Medicaid program abuse are unnecessary physician visits, unnecessary treatments and separate schedules of charges (higher charges for Medicaid patients than non-Medicaid patients).

Penalties for abusing or defrauding Medicaid are just as severe as they are for Medicare. A fraud conviction can be a truly devastating experience. Being convicted of Medicaid fraud can mean a heavy fine and/or a prison sentence and what's worse the loss of a fine professional reputation in the medical field.

Of course, as with Medicare, situations may occur that appear to be fraud but are really just an honest mistake or misunderstanding. Again documenting medical necessity in your patients' records and having a well-trained medical assistant staff are two sure-fire forms of "preventive" medicine.

Conclusion

You have now completed the second booklet in our three-part series about HCFA programs. Medicare and Medicaid are really very important programs, aren't they? They put good quality health care within the reach of the elderly, the disabled, the blind, the poor—all those people who need medical help the most.

We sincerely hope you find this booklet helpful. If you have any questions, please feel free to contact the people listed in Appendix A.

Appendix A

Alabama

Single State Agency:

Medical Services Administration
2500 Fairlane Drive
Montgomery, AL 36130
205/277-2710

Medical Assistance Unit:

same

Fiscal Agent:

Alacaid
P.O. Box 3367
Montgomery, AL 36109
205/834-3330

Florida

Single State Agency:

Department of Health & Rehabilitative Services
1323 Winewood Boulevard
Tallahasssee, FL 32301
904/488-7721

Medical Assistance Unit:

Social & Economic Services
Department of Health & Rehabilitative Services
1323 Winewood Boulevard
Tallahassee, FL 32301
904/488-5461

Fiscal Agent:

Systems Development Corp.
Integrated Services, Inc.
2670 Executive Center Circle West
Suite 200
Tallahassee, FL 32301
904/877-8121

Georgia

Single State Agency:

Georgia Department of Medical Assistance
1010 West Peachtree Street N.W.
Atlanta, GA 30309
404/894-4324

Medical Assistance Unit:

same

No fiscal agent
(Medicaid claims are paid by the State agency)

Kentucky

Single State Agency:

Bureau for Social Insurance
Department for Human Resources
DHR Building
Frankfort, KY 40601
502/564-4321

Medical Assistance Unit:

Division for Medical Assistance
Department for Human Resources
Frankfort, KY 40601
502/564-4321

No fiscal agent
(Medicaid claims are paid by the State agency)

Mississippi

Single State Agency:

Mississippi Medicaid Commission
4785 I-55 North
P.O. Box 16786
Jackson, MS 39206
601/354-7464

Medical Assistance Unit:

same

Fiscal Agent:

Blue Cross/Blue Shield of
Mississippi, Inc.
P.O. Box 3545
Jackson, MS 39207
601/932-3704

North Carolina

Single State Agency:

Department of Human Resources
325 N. Salisbury Street
Raleigh, NC 27611
919/733-4534

Medical Assistance Unit:

Division of Medical Assistance
Department of Human Resources
336 Fayetteville Street Mall
Raleigh, NC 27601
919/733-2060

Fiscal Agent:

Electronic Data Systems
Federal Corporation
P.O. Box 30968
Raleigh, NC 27612
919/851-8888

South Carolina

Single State Agency:

State Department of Social Services
P.O. Box 1520
Columbia, SC 29202
803/758-3244

Medical Assistance Unit:

Health Care Financing
State Department of Social Services
P.O. Box 1520
Columbia, SC 29202
803/758-8182

No Fiscal Agent
(Medicaid claims are paid by the State Agency)

Tennessee

Single State Agency:

Department of Public Health
344 Cordell Hull Building
Nashville, TN 37219
615/741-3111

Medical Assistance Unit:

Bureau of Medicaid Administration
and Coordination
Department of Public Health
283 Plus Park Boulevard
Nashville, TN 37219
615/741-6345

Fiscal Agent:

Electronic Data Systems
Federal Corporation
1101 Kermit Drive, Suite 300
Nashville, TN 37217
615/367-2105

BASIC ELIGIBILIT

State	Aged, blind & disabled	SSI	More restrictive standards	Optional cash[2] supplementation	Special income test for medical institutions & intermediate care facilities
AL		X		X	X
FL		X			X
GA		X			X
KY		X		X	
MS			X[3]		
NC			X	X	
SC		X		X	X
TN		X			

— Each State has additional coverage groups—for additional information contact should be made with the State Medicaid or Welfare agency in the appropriate State

— Payments for special needs

— Effective July 1, 1981, Mississippi will cover all SSI recipients rather than using more restrictive standards.

VERAGE BY STATE[1]

FDC	Families with unemployed parents	Unborn children	Aged, blind & disabled & families with children medically needy
X		X	
X		X	
X			
X	X	X	X
X		X	
X			X
X		X	X
X		X	X

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